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Doctors and Nurses, Still Learning

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By Theresa Brown, R.N.

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My patient was a young woman struggling with aggressive lymphoma who needed around-the-clock pain control. Because of her youth, and the hope that she might be cured, the attending physician was thinking of her future. He worried a patient-controlled analgesia pump could lead to a psychological dependence on narcotics..

For my part, it was hard to watch her struggle against the pain. "What about a fentanyl patch?" I suggested to the doctor, a "fellow'' who was second in command to the attending physician. Fentanyl patches are the pain-control version of nicotine patches for smokers, and they're a great way to treat chronic pain in cancer patients. It seemed like a good idea. A patch would give the patient more consistent pain relief and would obviate the doctor's concerns about overuse.

The fellow looked at me. "That's a terrible idea," he said, "to put a fentanyl patch on a patient who is having fevers." He didn't say it aggressively, or meanly. But he was very clear, and he was right. My idea was really, really terrible, even dangerous.

The doctor was referring to the fact that heat can interfere with the patch's slow-release mechanism, causing it to "dump" a large dose of fentanyl all at once. Some patients wearing the patches have died, and some of those deaths were likely caused by a patient applying a heating pad, or because a patient had a fever.

I knew about these risks because about six months earlier a flurry of e-mails went out to staff nurses alerting us to the dangers of combining fentanyl patches and heat. Stories about patient

deaths were posted in the break room, and fentanyl patches became a hot topic of conversation among the nurses on the floor. Remembering those discussions, I couldn't believe what I had just suggested. Everything I knew about fentanyl patches and fevers rushed to the front of my mind as a reproach, and nine months later the memory of this experience still fills me with shame.

A few weeks later I was caring for another patient who had been having fevers on and off. It was about 10 in the morning, three hours into my shift, and the time of day when we usually get our first chance to catch our breath, when it clicked in my head that my patient with the fevers was wearing a fentanyl patch for pain.

I paged the intern, the doctor-in-training who had my patient for the day, and half-asked, half-explained, "I'm wondering if you want to remove that fentanyl patch since the patient keeps spiking temps?"

The intern paused for a moment. I'm sure he was in the middle of morning rounds and busy, possibly even waiting to present a different patient, on another floor, to the attending physician. "No," he said, "It's a low dose — it'll be O.K."

Was there some condescension in his voice? I wasn't sure, but I decided to leave the question of what to do about the patch unanswered for the moment. Twenty minutes seemed like an acceptable amount of time to wait before repaging the intern. After all, he was right, it was a low dose. I had a few meds to give to my other patients, and afterwards I could flag down the charge nurse and ask her whether it was safe to leave the fentanyl patch on the patient.

The 20 minutes was almost up when my phone rang. It was the intern, calling to tell me he had checked with pharmacy about the fentanyl patch and the feverish patient. "They said it would be a good idea to remove it,'' he told me.

This time I wondered if he sounded embarrassed, but I didn't linger, just told him I'd remove the patch. "I feel better about that," I said.

I walked through the double doors that separate one part of my floor from another, on my way to remove the patch, when the intern himself came through the door from the other side. I had not met him before, but I recognized him by the name stitched on his long white coat.

We stopped in the doorway, he and I, for the briefest of conversations. I realized he definitely was embarrassed. I tried to reassure him. "That news about fevers and fentanyl came out maybe a year ago," I told him, trying to be neutral, to keep any flavor of judgment out of my voice. I knew from experience how bad it felt to make that particular mistake, and I didn't want to aggravate any bad feelings he already had.

He nodded at me and gave a small smile. I smiled back. Then he hurried through the doors to finish morning rounds, and I went back through the doors in the opposite direction, toward the patient whose patch needed to be removed.

In the book “Complications,” the surgeon Atul Gawande described the difficulties inherent in medicine being learned on the job: “The moral burden of practicing on people is always with us, but for the most part unspoken.” He explained that part of what blunts that moral burden is the supervision interns and residents get from more senior residents and attending physicians, who guide and instruct as needed. What Dr. Gawande did not say, and in my experience what also remains unspoken among nurses and doctors, is that floor nurses do some of that guiding and instructing, too. It’s an ad hoc, unsystematic part of medical education, but it can make a difference in patient care.

We all get emails, read journals and take classes, but still sometimes, in the hurly-burly of the modern hospital, crucial information can fall through individual mental cracks. At those times information gets passed on person to person: doctor to doctor, nurse to nurse, doctor to nurse, and sometimes even nurse to doctor.

Having doctors who are willing to educate nurses makes a difference, too. The fellow who took my suggestion about the fentanyl patch seriously enough to tell me it was a “terrible idea” cemented the information in my brain. When the issue came up again, I could raise it as a question for the intern, who then went to the pharmacy to complete his education.

There’s always more to learn, and no matter how hard any of us try, there’s rarely enough time for one person to learn it all.